DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 1 2

2. STATE: MICHIGAN

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ -0-(5.293) million BAH
b. FFY 2003 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pages 27 through 29

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, pages 27 through 29

10. SUBJECT OF AMENDMENT:
Changes GME payment base from cost-based liability to FTEs

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
James K Haveman Jr

13. TYPED NAME:
James K. Haveman, Jr.

14. TITLE:
Director

15. DATE SUBMITTED:
09-07-01

16. RETURN TO:
Michigan Department of Community Health
Office of Federal Liaison
6th Floor Lewis Cass Building
320 South Walnut Street
Lansing, Michigan 48913

ATTENTION: Nancy Bishop

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
9/10/01

18. DATE APPROVED:
12/6/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1-1-02 BAH.

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE:
Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
SEP 10 2001
DMCH - MI/MN/WI

FORM HCFA-179 (07-92)

Instructions on Back

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The add-on amount are an estimate of the statewide average paid to hospitals located in Michigan. Capital payments to out-of-state hospitals are not cost settled.

J. Graduate Medical Educaiton

Distribution of GME Funds
Distribution of graduate medical education funds will be calculated annually for two formula pools – the GME Funds and the Primary Care Pools. In order to receive funds for graduate medical education, a hospital must have operated a nationally accredited medical education program(s) in the fiscal year that data is drawn from the hospital cost reports used to calculate the GME payments. Payments will be fixed, prospective payments, made in full and are not subject to future cost settlement, or appeal. Payments will be made only to hospitals that provide requested information by the dates required. Payments will be made semi-monthly by gross adjustment. Separate gross adjustments will be made for each pool payment.

Only intern and resident FTEs in approved programs as specified in *Federal Regulations* (see 42 CFR 413.86) will be eligible for inclusion in the data used to calculate the distribution of the GME Funds and Primary Care Pools.

To distribute funds from the GME Funds and the Primary Care Pools, data will be drawn from accepted hospital cost reports for the most recent fiscal year that data is available. For the GME Funds Pool, the unweighted full-time-equivalent (FTE) count will be used (line 3.05 from E-3, Part IV). For the Primary Care Pool, the weighted FTE count for primary care physicians will be used (line 3.07 from E-3, Part IV). If the cost report is changed, equivalent data will be used.

Both the hospital and its residency programs must be operating during the funding period in order to receive GME funds. Hospitals must notify the department in writing at least 30 days prior to the termination date of any of its residency programs. Funds distributed to ineligible hospitals are subject to recovery.

GME payments to hospitals that merge during an academic year will be combined, provided that the surviving hospital continues to operate all residency programs that the pre-merger hospitals operated. The surviving hospital must notify the department within 30 calendar days after the merger is completed of any reductions or terminations to its residency programs. The GME payments to the surviving hospital will be reduced proportionately to the reduction in its GME programs. Overpayments to surviving hospitals based on reductions in GME programs are subject to recovery.

GME funds not distributed during an academic year, because a hospital closes or because one of its residency programs is terminated or is reduced in size, will be added to the GME Innovations Grants Pool for distribution during the next GME Innovations Grants awards cycle.

Participation in Medicaid Managed Care Program
In order to participate in the annual distribution of funds from either GME pool, a hospital must meet the following criteria:

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- If no Medicaid HMO has been authorized by Medicaid to enroll beneficiaries in the county in that the hospital is located or in a hospital's service area within the county, the hospital will be allowed to participate in the distribution of funds from this pool.
- If only a single Medicaid HMO has been authorized by Medicaid to enroll beneficiaries in the county that the hospital is located, then the hospital must have a signed agreement with that HMO.
- If two Medicaid HMOs have been authorized by Medicaid to enroll beneficiaries in the county, which the hospital is located, then the hospital must have a signed agreement with at least two of the HMOs.

At a minimum, agreements must provide for appropriately authorized, medically necessary inpatient hospital, outpatient hospital, emergency and clinical care arranged by a physician with admitting privileges to the facility.

Annual Report

To be eligible to receive payments from the GME Funds or Primary Care formula pools, hospitals are required to submit an annual report to the department. The report shall include sufficient information so that the department can determine the numbers of residents that completed their residency programs a minimum of three years prior to the fiscal year used to calculate distributions from the GME pools. The information will be used to determine the numbers for residents that are either currently participating in the Medicaid program and are board certified. The report will include, at a minimum, the following information:

- Hospital's Name, hospital's ID number, resident's name, resident's Social Security Number, Michigan physician license number, the resident's primary care or specialty care field, the year each resident completed his/her residency, and the resident's board certification status.
- Additional information regarding reporting requirements will be provided to hospitals by February 1, 2002. Hospitals will be required to submit the report on or before April 1st of each year.

The report format and completion instructions will be sent to each hospital by the department. Hospitals will be given a minimum sixty days in which to complete and return the report. Hospitals that fail to complete and return the required information within the specified time frame will be excluded from distribution of the GME pools.

GME Funds Pool

The dollar of amount of this pool is appropriated annually by the legislature. To calculate each eligible hospital's share of the GME Funds Pool, the following formulas will be used:

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$$FTEs \times Casemix \times (Hospital's\ TV\ \&\ TXIX\ Days / Hospital's\ Total\ Days) = Adjusted\ FTEs$$

$$[0.05 \times (\leq \$162.7\ Million) \times \frac{Hospital's\ Board\ Certified\ Physicians}{\sum\ Board\ Certified\ Physicians}] + [0.05 \times (\leq \$162.7\ Million) \times \frac{Hospital's\ Physicians\ Participating\ in\ Michigan\ Medicaid\ Program}{\sum\ Physicians\ Participating\ in\ Michigan\ Medicaid\ Program}] +$$
$$[0.9 \times (\leq \$162.7\ Million) \times (Adjusted\ FTEs / \sum\ Adjusted\ FTEs)] = Pool\ Distribution$$

Primary Care Pool
The dollar of amount of this pool is appropriated annually by the legislature. To calculate each hospital's share of the Primary Care Pool, the following formula will be used:

$$FTEs \times (Hospital's\ TV\ \&\ TXIX\ Outpatient\ Charges / Hospital's\ Total\ Charges) = Adjusted\ FTEs$$

$$[0.05 \times (\leq \$20\ Million) \times \frac{Hospital's\ Board\ Certified\ Physicians}{\sum\ Board\ Certified\ Physicians}] + [0.05 \times (\leq \$20\ Million) \times \frac{Hospital's\ Physicians\ Participating\ in\ Michigan\ Medicaid\ Program}{\sum\ Physicians\ Participating\ in\ Michigan\ Medicaid\ Program}] +$$
$$[0.9 \times (\leq \$20\ Million) \times (Adjusted\ FTEs / \sum\ Adjusted\ FTEs)] = Pool\ Distribution$$

Definitions/Notes
Title V & Title XIX Days – includes fee-for-service and managed care days. Days will include those from distinct-part psychiatric and distinct-part rehabilitation units.
Title V & Title XIX Outpatient Charges – includes fee-for-service and managed care outpatient charges. Charges will include those from distinct-part psychiatric units.
# of Residents Board Certified – number of residents board certified 3 years after completion of residency from a hospital. Hospital's Case Mix – the sum of the relative weights for all Medicaid admissions divided by the number of Medicaid admissions during the period covered.
# of Physicians Enrolled in the Michigan Medicaid Program 3 years after completion of residency from a hospital.
# of Hospital Eligible Resident FTEs – for the GME Funds and Primary Care Pools FTE data will be drawn from hospital cost reports as indicated above.

Implementation of Weighting Factors
The 5 percent weighting factors for physician participation in the Michigan Medicaid program and board certification will not be implemented until July 1, 2003. Until then, the above distribution formulas, without the weighting factors, will be used to distribute GME funds from the *GME Funds* and the *Primary Care Pools*.

However, to gain experience and to assess the impact of the new policy and formulas, hospitals will be required to begin reporting resident data in the Spring 2002. In order to implement the

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weighting factors for both physician participation in the Medicaid program and board certification, the department will use a five-year rolling average.

Based on information included in a hospital's report, the department will calculate the number of hospital residents participating in the Michigan Medicaid program. A physician must receive a minimum of $2,000 in payments from the Medicaid program, in the fiscal year that hospital cost report data is drawn, to be included in the "Physicians participating in the Medicaid program" weighting factor.

Hospitals will report on the board certification status of residents that completed their residency programs a minimum three years prior to the fiscal year that hospital cost report data is drawn in order to calculate the distribution of funds from the GME pools. Hospitals may report a physician that has been board certified each time the physician passes a board examination and is awarded certification during a five-year rolling average period.

Additional information regarding reporting requirements will be included in the report sent to hospitals for completion.

Three Year Phase- In of Revised GME Formula
In order to reduce the short-term impact that the revised formulas and distributions of GME funds will have on any hospital, the department will use a three-year phase in period. During the first full year, GME payments will be based three quarters on the prior distribution as established in MSA Bulletin 96-15, issued December 16, 1996, and one quarter based on the revised formula published in this bulletin. During the second year, the ratios will be one half each. In the third year, payments will be based on one quarter of the old formula and three quarters of the new formula. In the fourth year, GME payments will be made based entirely on the new formula.

GME Payments will be Prorated for the Current Academic Year
For the July 1, 2001 to June 30, 2002 academic year and payment period, GME payments will be prorated. During July 1 to December 31, 2001, GME payments will be calculated using the prior GME reimbursement schedule. For January 1 to June 30, 2002, GME payments will be calculated using the new formulas indicated above. Thereafter, the new formulas will be used to annually calculate and distribute GME funds appropriated by the legislature.

GME Innovations Grants
To encourage the training of health professionals for the future health care environment, a special pool will be established which will be distributed to projects or organizations that wish to develop innovative health professions education programs. The pool will be established bi-annually. The size of the pool will be subject to the availability of funds for the same state fiscal year in which payments for services are made. Competitive grants will be awarded to qualified applicants that respond to a request for proposal (RFP) issued by the department for this purpose. Grants will be awarded to projects that support public policy goals and priorities, as specified in the "Guiding Principles" above, and included in the RFP to be issued.

Grants will be awarded only for health professions education programs that are accredited by national and/or regional accrediting agencies. Improved care and treatment of Michigan Medicaid patients must be the focus of any grant awarded. Payments will be limited to enrolled Medicaid providers that will act as the fiduciary for the grantee. Grants may be

awarded for multi-year periods. Additional details will be included in the RFP released for these grants.

IV. Appeals

A. Price Appeals

The MSA will consider appeal requests received within thirty (30) calendar days from the date of notice to the hospital advising it of a change in its pricing components. Appeal requests must be submitted in writing to the MSA. Requests must clearly state the item(s) being appealed, the remedy being sought, and must include all necessary documentation to support the hospital's position. Appeal requests received after thirty (30) calendar days will not be accepted. Appeal requests may not be used as a means to delay submission or fail to produce cost reports in the format and within the time frame required. Failure to include all necessary documentation to support the hospital's position may result in a hospital's appeal request being rejected.

Items subject to appeal include:

1. Interpretations and/or application of program:
   a) Policy
   b) Procedures
   c) Formulas
   d) Pertinent laws and regulations (e.g. Code of Federal Regulations, HIM-15, etc.)
2. Incorrect data and/or paid claims information used in price calculations – excluding data and paid claims information from the hospital's annual cost report previously submitted by it and accepted by the MSA.

Items not subject to appeal include:

1. Data previously submitted by the hospital and accepted by the MSA
2. The establishment and use of DRGs
3. The Medicare Principles of Reimbursement (e.g. 42 CFR, HIM-15, etc.) as adopted by the MSA and used to reimburse providers
4. The use of relative weights as part of the DRGs
5 Interim payment rates which are in compliance with state and/or federal regulations, and
6. Non-program related issues

Appeal requests must be sent to: Appeals Section, Department of Community Health, P.O. Box 30479, Lansing, Michigan 48909.

B. Appeal Process

Upon receipt of an appeal request, a bureaau conference is scheduled and conducted by a MSA staff person from the Appeals Section. During this conference, issues related to the appeal are discussed by the MSA staff and hospital representatives.